Office of Billing Compliance
2015 Coding, Billing and Documentation Program

Department of OB/GYN/GYO
Documentation in the EHR - EMR
Volume of Documentation vs Medical Necessity

Annually OIG publishes its "targets" for the upcoming year. Included is EHR Focus and for practitioners could include:

Pre-populated Templates and Cutting/Pasting Documentation containing inaccurate or incomplete or not provided information in the medical record

- **REMEMBER:** More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the actual service provided on the DOS only.
General Principles of Documentation

- All documentation must be legible to all readers. Illegible documents are considered not medically necessary if it is useless to provide a continuum of care to a patient by all providers. Documentation is for the all individuals not just the author of the note.

- Per the Centers for Medicare and Medicaid services (CMS) practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
  - CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the date of service.
  - Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done, and this includes a signature.

- An addendum to a note should be dated and timed the day the information is added to the medical record and only contain information the practitioner has direct knowledge is true and accurate.
2015 Code Changes
New & Revised Codes

• New
  • **90630**  Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
  • **90651**  Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use

• Revised
  • **90654**  Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
  • **90721**  Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP/Hib), for intramuscular use
  • **90723**  Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use
  • **90734**  Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent, for intramuscular use

• Vaccines/Toxoids (90630, 90651, 90654, 90721, 90723, 90734 ) identify the vaccine product only. To report the administration of a vaccine/toxoid, the vaccine/toxoid product code must be used in addition to an immunization administration code(s) 90460, 90461, 90471, 90472, 90473, 90474.
Advance Care Planning (ACP)

Two new codes have been created for advance care planning, including completion of advance directive. Although this service is frequently provided by oncology physicians, it must be completely documented in the medical record in order to report the following codes:

• 99497: Advance care planning (ACP), including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

• 99498: each additional 30 minutes and should be listed separately and in addition to 99497.

CMS will not pay separately for this service in calendar year (CY) 2015, but it will consider separate payment in subsequent years.
ACP (Advanced Care Planning)

- An advance directive is a document that appoints an agent and/or records the wishes of a patient pertaining to his or her medical treatment at a future time should he or she lack decisional capacity at that time.

- To report the code(s), the patient need not be present as the discussion can also be between a physician or qualified healthcare professional and a family member or surrogate. Because the purpose of the visit is the discussion, no active management of the problem(s) is undertaken during this time period.

- Completion of relevant legal forms is also not required at the time of the discussion. It is important to note that this service is limited to advance care planning.

- As stated in the guidelines, certain E/M services performed on the same day may be reported separately.
Chronic Care Management (CCM)

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

AMA CPT Symposium: CMS clarify CCM billing:

• For the new monthly chronic care management (CCM) services, practices should bill the claim on “the last day of the calendar month for which the CCM service is billed,” according to a senior CMS official.
  • For example, if services began in January, practices would bill 99490 with the date of service of Jan. 31 to earn the about $40 payment.
• **1. CCM has no face-to-face visit requirement.** “We would in general assume that if a patient has two chronic conditions that the physician would want to see them, but it’s not part of this service,” said Kathy Bryant, CMS director of the division of practitioner services.

• **2. Outside providers can bill CCM services.** Asked whether providers could “contract out” CCM services to an outside agency or provider, Bryant replied, “it is an incident-to service and incident-to rules allow contracted providers, as long as the regulation is followed.”

• **3. CCM is not a capitated payment.** It’s “not a per-beneficiary, per-month payment,” Bryant warns. “We do not believe that in a fee-for-service system we have the capability to pay this way. You must provide 20 minutes of services during a calendar month to bill this code.”
Along those same lines, you can’t automatically charge for a CCM service for the care of a patient just because he has two chronic illnesses, warned David Ellington, M.D., of the AMA’s CPT Editorial Panel. The CCM patient is “not someone with two very stable illnesses,” he explained. Instead, the patient’s “chronic conditions place the patient at significant risk of death, acute exacerbation, decompensation or functional decline,” he added.

4. **Keep time records.** CMS doesn’t have a specific policy for how you should document your time when providing CCM services. “If it were up to me, I would keep actual time records,” Bryant said. According to CPT, if you record fewer than 20 minutes of CCM services per month, you can’t bill for the service. The usual CPT time conventions — which allow you to round up to a code’s required time when more than half the time is reached — do not apply for 99490, he says.
5. Inform the beneficiary when you start care. A Medicare patient may not see you in February, but she will have to pay a coinsurance in February for your CCM services, Bryant explains. To bill for CCM, you must inform the beneficiary so she will understand what’s going on, she adds.

6. Watch Medicare, CPT for place-of-service rules. As far as Medicare is concerned, CCM is a non-face-to-face service and has no requirement for place of service, Bryant said. However, CPT is a little stricter. The CPT manual specifies that a CCM patient is at home in a domiciliary, rest home or assisted living facility, Ellington pointed out. CCM was not meant to be a service performed for hospital inpatients, he said.
Reminder:
Transitional Care Management (TCM)

Identify Qualifying Patients — Services are applicable to any division who is managing the comprehensive responsibility for a patient’s care

- CPT® codes 99495 and 99496 represent the oversight, management, and/or coordination of services for all medical conditions, psychosocial needs, and activities of daily living support by providing first contact with the patient and continuous access by the provider for 30 days post-discharge.

Documentation must include:

- Timing of the initial post-discharge communication with the patient or caregivers
- Date of the face-to-face visit
- Care/Coordination provided
- Complexity of the MDM
- Medication reconciliation and management no later than date of the first face-to-face visit is included in TCM service.
**Basic requirements/rules per CMS**

<table>
<thead>
<tr>
<th>Post-discharge TCM codes</th>
<th>Type of MDM</th>
<th>Communicate within 2 business days* of discharge</th>
<th>Face-to-face visit within 7 days</th>
<th>Face-to-face visit once in 8 to 14 days</th>
<th>Payable once in 30 days per patient</th>
<th>Additional E/M service reportable</th>
<th>Billable during post-op period of 010 and 090 procedures</th>
<th>Patient may be new or established</th>
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<td>Moderate</td>
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<td>No***</td>
<td>Yes</td>
<td>Yes^^^^^</td>
<td>Yes •</td>
<td>No</td>
<td>√√√</td>
</tr>
<tr>
<td>99496</td>
<td>High</td>
<td>Yes **</td>
<td>Yes***</td>
<td>No</td>
<td>Yes^^^^^</td>
<td>Yes •</td>
<td>No</td>
<td>√√√</td>
</tr>
</tbody>
</table>

* Business days are counted as Monday through Friday, except holidays without respect to normal business hours.

**After two or more documented unsuccessful attempts at communication are made within a timely fashion, per CMS, keep trying until patient is reached.

***Per CMS, the face-to-face visit required for TCM services cannot be furnished by same provider on same day as the discharge management service.

^^^^^Once per/individual/group regardless of subsequent admit/discharge at 30 days post-discharge or after per CMS.

• After the first required face-to-face visit.

√√√Patient may be new to the practice. Provider may opt to bill new patient visit instead of TCM service code.
2015 Clarification Updates

Reporting the Confirmation of Pregnancy Visit

• The initial “OB” visit may be reported as an E/M service under certain conditions. Even if the patient has taken a home pregnancy test, the initial visit may still be billed as an E/M service as you will be officially confirming the pregnancy.

• When coding for the “initial ob visit”, there are a few things that have to be taken into consideration. First you have to determine if the patient is there for a confirmation of pregnancy or if the pregnancy has already been confirmed. The second thing that needs to be determined is if the OB record has been initiated. Once this has been established you can determine how the visit should be reported.
2015 Clarification Updates

• Here is an example to help clarify the issue:
  • If a patient presents with signs or symptoms of pregnancy or has had a positive home pregnancy test and is there to confirm pregnancy, this visit may be reported with the appropriate level E/M services code. However, if the OB record is initiated at this visit, then the visit becomes part of the global OB package and is not billed separately.

• If the pregnancy has been confirmed by another physician, you would not bill a confirmation of pregnancy visit.
  • The confirmation of pregnancy visit is typically a minimal visit that may not involve face to face contact with the physician (for an established patient). The physician may draw blood and prescribe prenatal vitamins during this initial visit and still report it as a separate E/M service as long as the OB record is not started.
2015 Clarification Updates

• Diagnostic Reporting Options:
  • V72.40 Pregnancy examination or test, pregnancy unconfirmed
  • V72.41 Pregnancy examination or test, negative result
  • V72.42 Pregnancy examination or test, positive result

• The physician should report V72.40 if the encounter is to test for a suspected pregnancy and the patient leaves without knowing the results.

• If the pregnancy test is negative, report code V72.41.

• Report code V72.42 if the pregnancy is confirmed but the obstetrical record is not initiated. This diagnosis code is also used when the physician sees the patient for the confirmation of pregnancy but will not be providing the global obstetric care.

• Global obstetrical care begins when antepartum services are provided, or the obstetrical record is initiated as part of the physician’s comprehensive obstetrics work-up which includes the comprehensive history and physical.
Teaching Physicians (TP) Guidelines

Billing Services When Working With Residents Fellows and Interns

All Types of Services Involving a resident with a TP Requires Appropriate Attestations In EHR or Paper Charts To Bill
Evaluation and Management (E/M)

**E/M IP or OP:** TP must **personally document** by a personally selected macro in the EMR or handwritten at least the following:

- That s/he was **present** and performed key portions of the service in the presence of or at a separate time from the resident; **AND**
- The **participation** of the teaching physician in the management of the patient.

**Initial Visit:** “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that the picture is more consistent with an upper respiratory infection not pneumonia. Will begin treatment with........”

**Initial or Follow-up Visit:** “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

**Follow-up Visit:** “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”

**Follow-up Visit:** “I saw and evaluated the patient. Agree with resident’s note, but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

The documentation of the Teaching Physician must be patient specific.
Evaluation and Management (E/M)

Time Based E/M Services: The TP must be present and document for the period of time for which the claim is made. Examples:

- Critical Care Hospital Discharge (>30 minutes) or
- E/M codes where more than 50% of the TP time spent counseling or coordinating care

Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical student must be re-performed and documented by a resident or teaching physician.
Unacceptable TP Documentation

• Assessed and Agree
• Reviewed and Agree
• Co-signed Note
• Patient seen and examined and I agree with the note
• As documented by resident, I agree with the history, exam and assessment/plan
TP Guidelines for Procedures

**Minor** – (<5 Minutes): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

Example: ‘I was present for the entire procedure.’

**Major** – (>5 Minutes)

- SINGLE Procedure / Surgery — When the teaching surgeon is present or performs the procedure for a single non-overlapping case involving a resident, he/she or the resident can document the TP’s physical presence and participation in the surgery.

Example: “I was present for the entire procedure (or key and critical portions & description of the key and critical portions of the procedure and immediately available).”

**Deliveries** (Delivery-only codes (59409, 59514, or 59612, 59620) -

TP must be present during key portions of each stage of delivery.

- Admission to the hospital (admission H&P)
- Uncomplicated labor and infant delivery
- Delivery of Placenta
Overlapping Surgeries: CMS Requires

2 Overlapping Surgeries - CMS will pay for two overlapping surgeries, but the teaching surgeon must be present during the critical or key portions of both operations. Consequently, the critical or key portions may not take place at the same time.

✓ The teaching surgeon must **personally document** in the medical record that he/she was physically present during the critical or key portion(s) of both procedures

✓ When a TP is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, **he or she must arrange for another qualified attending surgeon to immediately assist the resident in the other case should the need arise** (this cannot be a resident or fellow.)

➢ **In the case of 3 concurrent surgical procedures, the role of the teaching surgeon in each of the cases is classified as a supervisory service** to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.
High-Risk Procedures & Diagnostic Services

Complex or high-risk procedures: Requires personal (in person) supervision of its performance by a TP and is billable only when the TP is present with the resident for the entire procedure. These procedures typically include cardiac and other interventional services.

• Example: “Dr. TP (or I) was present for the entire (identify procedure).”

Diagnostic services with an interpretation: If documented by a resident to be billed by a TP requires that s/he personally document that s/he personally reviewed the images, tracing, slides etc. and the resident’s interpretation and either agrees with it or edits the findings.

• Example: “I personally reviewed the films (and/or slides etc.) and agree with the resident’s findings.”
Diagnostic Procedures

• **Ultrasound, Radiology AND OTHER DIAGNOSTIC TESTS**

• **General Rule:** The Teaching Physician may bill for the interpretation of diagnostic Radiology and other diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician with modifier 26 in the hospital setting.

• **Teaching Physician Documentation Requirements:**
  - Teaching Physician prepares and documents the interpretation report.
  - OR
  - Resident prepares and documents the interpretation report
  - The Teaching Physician must document/dictate: “I personally reviewed the film/recording/specimen/images and the resident’s findings and agree with the final report”.

• **A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.**
The CPT descriptions of documentation requirements for many ophthalmic diagnostic tests include the phrase, "with interpretation and report." Once the appropriate individual has performed the test, you must document your interpretation of the results somewhere in the medical records. This doesn't have to be anything elaborate.

It may merely be a brief phrase indicating if a test is "normal," "stable from a previous test" or "mild superior arcuate defect."
Preventive Well Woman 99381-99395

The extent and focus of the services will largely depend on the age of the patient. Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination.

The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is not synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing preventive services, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate code should also be reported with Modifier 25.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine service and which does not require significant additional work and the performance of the key components of a problem-oriented E/M service should not be reported.
Medicare Well Woman

Medicare will reimburse for G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and Q0091 (Pap Smear) if it has been 2 years since the patient has had these services or annually if the patient meets the criteria for high-risk.

High risk factors for cervical and vaginal cancer are any one of the following:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (five or more in a lifetime);
- History of sexually transmitted disease (including human immunodeficiency virus {HIV});
- Fewer than three negative Pap smears within the previous 7 years;
- Prenatal exposure to diethylstilbestrol – Exposed daughters of women who took DES during pregnancy.

Source: Noridian Medicare Services
Screening Breast & Pelvic Exam: G0101

• Documentation MUST include at least 7 of the following 11 elements:
  1. Inspection and palpation of breasts
  2. Digital rectal exam including sphincter tone, presence of hemorrhoids, masses
• Pelvic exam (with or without specimen collection for smears and cultures) including:
  3. External genitalia (e.g., general appearance, hair distribution, lesions)
  4. Urethral meatus (e.g., size, location, lesions, prolapse)
  5. Urethra (e.g., masses, tenderness, scarring)
  6. Bladder (e.g., fullness, masses, tenderness)
  7. Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
  8. Cervix (e.g., general appearance, lesions, discharge)
  9. Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
10. Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
11. Anus and perineum
How to Handle Post-Hysterectomy Pap Claims

**Problem:** When a Medicare patient returns after a hysterectomy (for a malignant condition) for follow-up vaginal Pap smears in your office, should you report 99212 or 99213, or should you just report Q0091?

First of all, you should not report Q0091 (*Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory*), because this code refers to collection of a screening Pap smear.

After a hysterectomy that the OBGYN performed to treat cancer, all of the Paps will be diagnostic, not screening. Therefore, you should report the Paps with an E/M code (for example, 99213, *Office or outpatient visit for the evaluation and management of an established patient* ...), but payers now include the collection in the E/M service.
If Pap is 6 yrs. Post hysterectomy?

Should you submit Q0091?

If the purpose of the E/M visit is to follow up for the patient's cancer, then the Pap smear is diagnostic.

If the GYN wishes to put the patient back into the screening group, then she reverts to one Pap smear every two years instead of one each year, under Medicare rules, because the Medicare criteria list for screening each year does not include a history of cancer (for example, V10.42, Personal history of malignant neoplasm; other parts of uterus).

If the physician believes the patient requires a yearly Pap smear, considering her history, it will have to be a diagnostic service with the collection of the specimen included in the E/M code.
Q. Patients often present for a preventive exam and also ask for evaluation and management of specific problems (e.g., heartburn, chest pain). Is it appropriate to submit both a preventive medicine services code with a diagnosis code for a general medical exam and an appropriate office visit code with a diagnosis code for the specific problem?

A. Yes, as long as the documentation supports a separately identifiable E/M with a 25 modifier

In the notes preceding the Preventive Medicine Services codes, CPT states that "if an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine [E/M] service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office/outpatient code 99201-99215 should also be reported."
Global Surgery
Global Service: 1 payment for procedure

Major = Day before procedure thru 90 days after
Minor = Day of procedure (some until 10 days after)

Services **Included** In The Global Surgery Fee

- Preoperative visits, beginning with the day before a surgery for major procedures and the day of procedure for minor procedures.
- Complications following procedure, which do not require additional trips to the operating room.
- Postoperative visits (follow up visits) during the postoperative period of the procedure that is related to recovery from the surgery.
- Postoperative pain management provided by the surgeon.
Services Not Included in the Global Surgery Fee

- Visits unrelated to the diagnosis for which the surgical procedure is performed. Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery. Append modifier -24 to the E/M code.

- Treatment for postoperative complications that cause a return trip to the operating room, including ASCs and hospital outpatient departments. Append modifier -78 to the procedure code for the procedure provided in the operating room.

- Diagnostic tests and procedures, including diagnostic radiological procedures (no modifier required).

- Critical Care services (codes 99291 and 99292) unrelated to the surgery, or the critical care is above and beyond the specific anatomic injury or general surgical procedure performed. Immunosuppressive therapy for organ transplants.
Modifiers: Provider Documentation MUST Support the Use of All Modifiers

A billing code **modifier** allows you to indicate that a procedure or service has been altered by some specific circumstance but has not changed in its definition.

**Modifiers allow to:**
- Increase reimbursement
- Indicate specific circumstances
- Facilitate correct coding
- Prevent denial of services
- Provide additional information

Documentation in the operative report must support the use of any modifier.
Major Surgery Modifier Reminders
**Modifier 22**

- Services performed are significantly greater than usually required", therefore its use should be exceptional. Example: extensive lysis of adhesions while performing a C-section or severe obesity that required significant additional time and effort. OP report should include documentation of the specific events that “significant additional time and effort” for the procedure.

**Modifier 57**

- Significant, Separately Identifiable E/M by the Same Physician/Group on the Day of or within 24 hours of a major procedure.

**Modifier 52**

- Surgeries for which services performed are significantly less than usually required may be billed with the "-52" modifier.

**Modifier 53**

- Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. Documentation describing the circumstances requiring the discontinuation of a procedure in the report is required.

**Modifier 58**

- Staged or planned related surgical procedures done during the global period of the first procedure. Procedure may have been: Planned prospectively or at the time of the original procedure; More extensively than the original procedure; or for therapy following a diagnostic surgical procedure. A new post-operative period begins when the next procedure in the series is billed.
Modifier 62: Co-Surgery

- Two surgeons (usually with different skills) with specialized skills act as co-surgeons. Both are primary surgeons, performing distinct parts of a single reportable procedure (same CPT code) performing the parts of the procedure simultaneously. (pays 125% of fee schedule)
- Co-surgery may be required because of the complexity of the procedure and/or the patient’s condition
- The additional surgeon is not working as an assistant, but is performing a distinct part of the procedure
- Each surgeon dictates his/her operative note describing his/her involvement in the procedure
• In general, the services of assistants for surgeries furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service is non-payable.

• However, it is covered if such services are exceptional medical circumstances. The TP must document in the operative note that a qualified resident was unavailable for the procedure and Documentation of qualifying circumstances must be included in the operating report.

• Only one OP report is required and the primary attending physician must document in their OP report the specific participation of the assistant (Dr. XXX assisted me throughout the entire procedure...”)

• If the assistant is a physician append modifier 82 to their claim. If the assistant is a PA append an AS modifier to their claim.

• Examples may be an emergency or complex C section or other GYN surgery
Minor Procedure With an E/M
### 000, 010 and XXX Procedures

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>17250000</td>
<td>Chemical cauterization of granulation tissue</td>
</tr>
<tr>
<td>51700000</td>
<td>Bladder irrigation, simple, lavage and/or instillation</td>
</tr>
<tr>
<td>51726000</td>
<td>Complex cystometrogram (ie, calibrated electronic equipment);</td>
</tr>
<tr>
<td>51729000</td>
<td>Complex cystometrogram; with voiding pressure studies technique</td>
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<tr>
<td>51741XXX</td>
<td>Complex uroflowmetry (eg, calibrated electronic equipment)</td>
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<tr>
<td>51784000</td>
<td>EMG, any technique</td>
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<tr>
<td>52000000</td>
<td>Cystourethroscoopy (separate procedure)</td>
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<tr>
<td>56821000</td>
<td>Colposcopy of the vulva; with biopsy(s)</td>
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<tr>
<td>57135010</td>
<td>Excision of vaginal cyst or tumor</td>
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<tr>
<td>57420000</td>
<td>Colposcopy of the entire vagina, with cervix if present;</td>
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<tr>
<td>57454000</td>
<td>Colposcopy</td>
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<tr>
<td>57500000</td>
<td>Biopsy of cervix (separate procedure)</td>
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<tr>
<td>58100000</td>
<td>Biopsy endometrial (separate procedure)</td>
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## 000, XXX Procedures

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<td>58300XXX</td>
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<tr>
<td>58301000</td>
<td>Removal IUD</td>
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<tr>
<td>58340000</td>
<td>Catheterization and introduction for saline infusion SIS or hysterosalpingography</td>
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<tr>
<td>59025000</td>
<td>Fetal non-stress test</td>
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<tr>
<td>76817XXX</td>
<td>Ultrasound, pregnant uterus, transvaginal</td>
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<tr>
<td>76830XXX</td>
<td>Ultrasound, transvaginal</td>
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<tr>
<td>76831XXX</td>
<td>Saline infusion SIS, including Doppler, when performed</td>
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<tr>
<td>76856XXX</td>
<td>Ultrasound, pelvic (nonobstetric)</td>
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<tr>
<td>77080XXX</td>
<td>DXA, bone density study</td>
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<tr>
<td>77080XXX</td>
<td>DXA, axial skeleton</td>
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<tr>
<td>G0101XXX</td>
<td>Pelvic and breast exam</td>
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<tr>
<td>Q0091XXX</td>
<td>Screening Pap</td>
</tr>
<tr>
<td>S0612XXX</td>
<td>Annual gynecological examination, established patient</td>
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<tr>
<td>99406XXX</td>
<td>Smoking cessation</td>
</tr>
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Modifier 25: 000 or 010 Global Days

• If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure.

• *In general* E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure.

• The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service.

• However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.

• If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure in and of itself.
Modifier 25: XXX Procedures

- Procedures with a global surgery indicator of “XXX” are not generally covered by global rules and many are diagnostic in nature.
- “XXX” procedures performed by physicians have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed.
  - This work should never be reported as a separate E&M code. Communicating diagnostic results to a patient after the performance of a diagnostic service (if you are also the performing practice for the diagnostic) would not typically be billable if the diagnostic results could have been communicated to a patient over the phone with follow-up instructions.
- With many “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code.
  - This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure.
NCCI Manual: Modifier 25

What this is saying is that the E/M required to address the patient's specific chief complaint(s) is included in the reimbursement for the billable minor procedure. This would include determining the chief complaint(s), taking or updating history, review of systems, examining the patient, past family/social history, diagnosing the problem, making the decision on how to treat the problem, informing the patient, obtaining consent, and providing postop instructions. In summary, none of the aforementioned tasks/processes can be billed for separately if they are related to a billable minor procedure.

The exception, is when there is a "separately identifiable" E/M service performed during that visit that goes "above and beyond" the E/M necessary for the billable minor procedure.

Additional Articles of Interest
OIG Cracking Down on Modifier 25 Use
E/M Update: DOJ Targets Improper Use of Modifier 25
Almost never billable when a patient is pre-scheduled for a procedure

• Here is a SIMPLE way to look at it...

Take the chart note for the date of service in question, take a highlighter, and highlight all the documentation related to performing the procedure including the documentation required for evaluating, diagnosing, examining the patient, making the decision to perform the procedure in question, performing the procedure, and providing postoperative instructions and any prescriptions. Now, if the remaining documentation from that date of service can stand alone as a billable E/M visit (with all the appropriate elements required), then there is a high probability that this will stand as a “separate and identifiable” E/M visit.

Note: The rules about “separate and identifiable” E/M visits apply to BOTH new patient and established patient E/M visits.
Major or Minor Procedure Modifier Reminders
Modifier 59: Distinct Procedural Service

- Designates instances when *distinct* and *separate multiple services* are provided to a patient on a single date of service and should be paid separately.
- Modifier-59 is defined for use in a wide variety of circumstances to identify:
  - Different encounters Different anatomic sites (Different services (Most commonly used and frequently incorrect).
- 4 new modifiers to define subsets of Modifier-59:
  - **XE - Separate Encounter**, a service that is distinct because it occurred during a separate encounter. Used infrequently and usually correct.
  - **XS - Separate Structure**, a service that is distinct because it was performed on a separate organ/structure. Less commonly used and can be problematic.
    - Biopsy on one lesion and excision on another. Biopsy is "bundled" into excision, therefore must properly bill biopsy CPT with a 59 modifier to indicate separate structure.
  - **XP – Separate Practitioner**, a service that is distinct because it was performed by a different practitioner.
  - **XU – Unusual non-overlapping service**, the use of a service that is distinct because it does not overlap usual components of the main service.

Only a practitioner or coder should designate a modifier 59 to a claim (not a biller) based exclusively on the procedure note details – not OP report headers.
 Modifier GC
CMS Manual Part 3 - Claims Process - Transmittal
1723

Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service when working with a resident or fellow

Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service.
Inpatient, Outpatient and Consultations

Evaluation and Management E/M

Documentation and Coding
What is the definition of "new patient" for billing E/M services?

• “New patient" is a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.

• An interpretation of a diagnostic test, reading an x-ray or EKG etc., (billed with a -26 modifier) in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.
E/M Key Components

- **History (H)** - Subjective information
- **Examination (E)** - Objective information
- **Medical Decision Making (MDM)** – The assessment, plan and patient risk

The billable service is determined by the combination of these 3 key components.
- All 3 Key Components are required to be documented for all E/M services.
- For coding the E/M level
  - New OP and initial IP require all 3 components to be **met or exceeded** and
  - Established OP and subsequent IP require 2 of 3 key components to be **met or exceeded and one must be MDM**.

When downcoded for “medical necessity” on audit, it is often determined that documented H and E exceeded what was deemed “necessary” for the visit (MDM.)
Elements of an E/M History

The extent of information gathered for history is dependent upon clinical judgment and nature of the presenting problem.

Documentation of the patient’s history includes some or all of the following elements:

- Chief Complaint (CC) and History of Present Illness (HPI) are required to be documented for every patient for every visit

**WHY IS THE PATIENT BEING SEEN TODAY**

- Review of Systems (ROS)

- Past Family, Social History (PFSH)
History of Present Illness (HPI)
A KEY to Support Medical Necessity to in addition to MDM

• HPI is chronological description of the development of the patient’s present illness or reason for the encounter from the first sign and/or symptom or from the previous encounter to the present or the status of chronic conditions being treated at this visit.
  • The HPI must be performed and documented by the billing provider in order to be counted towards the level of service billed.

  Focus upon present illness or reason for the visit!

• HPI drivers:
  • Extent of PFSH, ROS and physical exam performed

• NEVER DOCUMENT PATIENT HERE FOR FOLLOW-UP WITHOUT ADDITIONAL DETAILS OF REASON FOR FOLLOW-UP. This would not qualify as a CC or HPI.
HPI

• Status of chronic conditions being managed at visit
  • Just listing the chronic conditions is a medical history
  • Their status must be addressed for HPI coding

• Documentation of the HPI applicable elements relative to the diagnosis or signs/symptoms being managed at visit
  • Location
  • Quality
  • Severity
  • Duration
  • Timing
  • Context
  • Modifying factors
  • Associated signs and symptoms
Review of Systems (ROS)

- Constitutional
- Eyes
- Respiratory
- Ears, nose, mouth, throat
- Cardiovascular
- Musculoskeletal
- Gastrointestinal
- Genitourinary
- Psychiatric
- Integumentary
- Neurologic
- Allergy/Immunology
- Endocrine
- Hematologic/Lymphatic

ROS is an inventory of specific body systems in the process of taking a history from the patient. The ROS is designed to bring out clinical symptoms which the patient may have overlooked or forgotten. In theory, the ROS may illuminate the diagnosis by eliciting information which the patient may not perceive as being important enough to mention to the physician relative to the reason for the visit.
Past, Family, and/or Social History (PFSH)

- **Past history:** The patient’s past medical experience with illnesses, surgeries, & treatments. May also include review of current medications, allergies, age appropriate immunization status

- **Family history:** May include a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk or Specific diseases related to problems identified in the Chief Compliant, HPI, or ROS

- **Social history:** May include age appropriate review of past and current activities, marital status and/or living arrangements, use of drugs, alcohol or tobacco and education.

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services. **Don't use the term "non-contributory” for coding a level of E/M**
Examination

4 TYPES OF EXAMS

- Problem Focused (PF)
- Expanded Problem Focused (EPF)
- Detailed (D)
- Comprehensive (C)
# Coding 1995: Physical Exam

## Body Areas (BA):
- Head, including face
- Neck
- Chest, including breast and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

## Coding Organ Systems (OS):
- Constitutional/General
- Eyes
- Ears/Nose/Mouth/Throat
- Respiratory
- Cardiac
- GI
- GU
- Musculoskeletal
- Skin
- Neuro
- Psychiatric
- Hematologic/Lymphatic
1997 Sub-Specialty Physical Exam

• Cardiovascular
• Musculoskeletal
• Ears, Nose, Mouth and Throat
• Neurological
• Eyes
• Skin

• Psychiatric
• Genitourinary (Female) (Male)
• Respiratory
• Hematologic / Lymphatic / Immunologic
• General Multi-system Exam
## GU Examination for Female

### Constitutional
- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

### Neck
- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (e.g., enlargement, tenderness, mass)

### Respiratory
- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

### Cardiovascular
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)

### Gastrointestinal (Abdomen)
- Examination of abdomen with notation of presence of masses or tenderness
- Examination for presence or absence of hernia
- Examination of liver and spleen
- Obtain stool sample for occult blood test when indicated

### Genitourinary

**FEMALE:**

Includes at least seven of the following eleven elements identified by bullets:
- Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge)
- Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses
- Pelvic examination (with or without specimen collection for smears and cultures) including:
  - External genitalia (e.g., general appearance, hair distribution, lesions)
  - Urethral meatus (e.g., size, location, lesions, prolapse)
- Urethra (e.g., masses, tenderness, scarring)
- Bladder (e.g., fullness, masses, tenderness)
- Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
- Cervix (e.g., general appearance, lesions, discharge)
- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
- Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
- Anus and perineum
1995 and 1997 Exam Definitions

Problem Focused (PF): 99231, 99212 or 99201
- ‘95: Limited exam of the affected body area or organ system. (1 BA/OS)
- ‘97=Specialty and GMS: 1-5 elements identified by bullet.

Expanded Problem Focused (EPF): 99232, 99213 or 99202
- ‘95: Limited exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- ‘97=Specialty and GMS: At least 6 elements identified by bullet.

Detailed (D): 99233, 99221, 99214 or 99203
- ‘95: Extended exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- 97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc)

Comprehensive (C): 99222, 99223, 99215 or 99204 and 99205
- ‘95: General multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- ‘97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.
Medical Decision Making (MDM)

**DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE TODAY!!**

Exchange of clinically reasonable and necessary information and the use of this information in the clinical management of the patient

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**Step 1:**
- Number of possible diagnosis and/or management options affecting today's visit. List each separate in A/P and address every diagnosis or management option from visit. Is the diagnosis and/or management options:
  - "New" self-limiting: After the course of prescribed treatment is it anticipated that the diagnosis will no longer be exist (e.g. otitis, poison ivy, ...)
  - New diagnosis with follow-up or no follow-up (diagnosis will remain next visit)
  - Established diagnosis that stable, worse, new,

---

**Step 2:**
- Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
  - Labs, radiology, scans, EKGs etc. reviewed or ordered
  - Review and summarization of old medical records or request old records
  - Independent visualization of image, tracing or specimen itself (not simply review of report)

---

**Step 3:**
- The risk of significant complications, morbidity, and/or mortality with the patient’s problem(s), diagnostic procedure(s), and/or possible management options.
  - # of chronic conditions and are the stable or exacerbated (mild or severe)
  - Rx’s ordered or renewed. Any Rx toxic with frequent monitoring?
  - Procedures ordered and patient risk for procedure

---

Note: The 2 most complex elements out of 3 will determine the overall level of MDM
### MDM Step 1: # Dx & Tx Options

#### Number of Diagnosis or Treatment Options – Identify Each That Effects Patient Care For The DOS

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max=1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New prob. (To examiner); additional workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Total**

1 POINT: E- 2, NEW-1,2 IP Level 1

2 POINTS: E-3, NEW-3 IP Level 1

3 POINTS: E-4, NEW-4 IP Level 2

4 POINTS: E-5, NEW-5 IP –Level 3
## MDM Step 2: Amt. & Complexity of Data

### Amount and/or Complexity of Data Reviewed – Total the points

<table>
<thead>
<tr>
<th>REVIEWED DATA</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report).</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>66</td>
</tr>
</tbody>
</table>

1 POINT: E-2, NEW-1, IP Level 1

2 POINTS: E-3, NEW-3, IP Level 1

3 POINTS: E-4, NEW-4, IP Level 2

4 POINTS: E-5, NEW-5, IP –Level 3
MDM Step 3: Risk Table for Complication

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

**DG:** Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention.
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min Risk</td>
<td>• One self-limited / minor problem</td>
<td>• Labs requiring venipuncture</td>
<td>• Rest   Elastic bandages Gargles   Superficial dressings</td>
</tr>
<tr>
<td>E-2, New–1</td>
<td></td>
<td>• CXR  EKG/ECG    UA</td>
<td></td>
</tr>
<tr>
<td>Low Risk</td>
<td>• 2 or more self-limited/minor problems</td>
<td>• Physiologic tests not under stress (PFT)</td>
<td>• OTC meds</td>
</tr>
<tr>
<td>E-3, NEW-3</td>
<td>• 1 stable chronic illness (controlled HTN)</td>
<td>• Non-CV imaging studies (barium enema)</td>
<td>• Minor surgery w/no identified risk factors</td>
</tr>
<tr>
<td>IP - 1</td>
<td>• Acute uncomplicated illness / injury (simple sprain)</td>
<td>• Superficial needle biopsies</td>
<td>• PT, OT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Labs requiring arterial puncture</td>
<td>• IV fluids w/out additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Skin biopsies</td>
<td></td>
</tr>
<tr>
<td>Mod Risk</td>
<td>• 1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment</td>
<td>• Physiologic tests under stress (stress test)</td>
<td>• Prescription meds</td>
</tr>
<tr>
<td>E-4, NEW-4</td>
<td>• 2 or more chronic illnesses</td>
<td>• Diagnostic endoscopies w/out risk factors</td>
<td>• Minor surgery w/identified risk factors</td>
</tr>
<tr>
<td>IP-2</td>
<td>• Undiagnosed new problem w/uncertain prognosis</td>
<td>• Deep incisional biopsies</td>
<td>• Elective major surgery w/out risk factors</td>
</tr>
<tr>
<td></td>
<td>• Acute illness w/systemic symptoms (colitis)</td>
<td>• CV imaging w/contrast, no risk factors (arteriogram, cardiac cath)</td>
<td>• Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>• Acute complicated injury</td>
<td>• Obtain fluid from body cavity (lumbar puncture)</td>
<td>• IV fluids w/additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Closed treatment, FX / dislocation w/out manipulation</td>
</tr>
<tr>
<td>High Risk</td>
<td>• 1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment</td>
<td>• CV imaging w/contrast, w/risk factors</td>
<td>• Elective major surgery w/risk factors</td>
</tr>
<tr>
<td>E-5,</td>
<td>• Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)</td>
<td>• Cardiac electrophysiological tests</td>
<td>• Emergency surgery</td>
</tr>
<tr>
<td>NEW-5</td>
<td>• Abrupt change in neurologic status (TIA, seizure)</td>
<td>• Diagnostic endoscopies w/risk factors</td>
<td>• Parenteral controlled substances</td>
</tr>
<tr>
<td>IP –3</td>
<td></td>
<td></td>
<td>• Drug therapy monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• DNR</td>
</tr>
</tbody>
</table>
Using Time to Code 
Counseling /Coordinating Care (CCC)

Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is CCC. Time is only Face-to-face for OP setting.

Coding based on time is generally the exception for coding. It is typically used when there is a significant exacerbation or change in the patient’s condition, non-compliance with the treatment/plan or counseling regarding previously performed procedures or tests to determine future treatment options.

Required Documentation For Billing:
1. Total time of the encounter excluding separate procedure if billed
   • The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated to counseling / coordination of care
3. The specific nature of counseling/coordination of care for that patient on that date of service. A template statement would not meet this requirement.
Counseling /Coordinating Care (CCC)?

Documentation must reflect the specific issues discussed with patient present.

Proper Language used in documentation of time:

• “I spent ____ minutes with the patient and over 50% was in counseling about her diagnosis, treatment options including _______ and ______.”
• “I spent ____ minutes with the patient more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)”
• “This entire ______ minute visit was spent counseling the patient regarding _________ and addressing their multiple questions.

Total time spent and the time spent on counseling and/or coordination of care must be documented in the medical record.
Genetic Counseling: CPT 96040

• 96040: Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
  • The trained genetic counselor meets with an individual, couple, or family to investigate family genetic history and assess the risks associated with genetic defects in offspring. This code covers 30 minutes of face-to-face counseling, review of medical data, or data collection (interviews).

• Issue: Medicare and many insurers do not pay for Genetic Counseling as a professional fee when provided by a genetic counselor.

• In the AMA CPT Code book the following instruction is listed.
  • For genetic counseling and education provided to an individual by a physician or other qualified health care professional who may report evaluation and management services, see the appropriate Evaluation and Management codes.
Genetic Counseling

• For billing and reimbursement purposes, the Genetic Counselor is NOT an independent practitioner who can provide services that can be reimbursed unless specific contractual agreements are made with a specific insurer.

• For most patients, the reimbursement code used depends upon the physician services provided, not on services provided by the Genetic Counselor.

• Therefore, when providing genetic counseling and using a time-based component of counseling and coordination of care, the level of service is based on the physician’s time with the patient.
  • This time based system does NOT include the time the Genetic Counselor spends with the patient obtaining a history and pedigree or providing information to the patient.
  • This situation may vary when there are specific contractual agreements that allow for Genetic Counseling to be done by a non-physician Genetic Counselor and the specific codes specified in that contract must be utilized.
Genetic Counseling Billing

• Unless a contractual arrangement has been made and the Genetic Counselors services can be bill to the insurer:
  • Genetic Counseling done by Counselor who spends 45 minutes with the patient and physician does not see the patient that day but is in the office suite.
    • Bill “incident-to” 99211 (POS 11) Doctor’s Office
  • Genetic Counseling done by Counselor and physician also spends 15 minutes with the patient reviewing the findings of the Genetic Counselor.
    • 99213 for an established patient
    • 99213-25 for patient receiving Global Obstetric Care from this office
In-Patient Hospital Care
Present on Admission (POA) & Hospital-Acquired Conditions (HAC)

- POA is defined as being present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA;

- Under the Hospital-Acquired Conditions—Present on Admission (HAC-POA) program, accurate coding of hospital-acquired conditions (HACs) and present on admission (POA) conditions is critical for correct payment.

- The importance of consistent, complete documentation in the medical record from any and all Physicians/Practitioners involved in the care and treatment of the patient is used to determine whether a condition is POA;

- It is crucial that physicians/practitioners document all conditions that are present on admission;

- The Hospital must include the POA indicator on all claims that involve Medicare inpatient admissions. The hospital is subject to a law or regulation that mandates the collection of POA indicator information.
USING DIFFERENT LEVELS OF CARE

99223 *
PATIENT
ADMITTED

99233 *
(PT. IS
UNSTABLE)

99232 *
(PT. HAS
DEVELOPED
MINOR COMPL.)

99231 *
(PT. IS
STABLE,
RECOVERING,
IMPROVING)

99238 *
PATIENT
DISCHARGED
Admission to Hospital - Two-Midnight Rule

• If the physician expects a patient’s stay to cross at least 2 midnights, and is receiving medically necessary hospital care, the stay is generally appropriate for inpatient admission.

• Must have a clear inpatient order written and signed before discharge. Physician or practitioner must be:
  • Licensed by the state to admit patients to hospitals
  • Granted privileges by the facility to admit
  • Knowledgeable about the patients hospital course, medical care, and current condition at the time of admission

• Must have documentation to support certification
• Anticipated length of stay
• Discharge planning
Does the physician expect the patient to require more than two midnights of hospital care that cannot be performed at a lower level of care? This includes care provided in the emergency room and/or if the patient is transferred to the hospital.

- **NO**: Is the patient receiving an Inpatient only procedure? (Consult case management)
  - **NO**: Is the patient newly ventilated? (Excluding ventilation during surgery)
    - **NO**: Write an order for Outpatient OR Outpatient Observation Status
    - **YES**: Write an Inpatient Order along with expected length of stay
  - **YES**: Write an Inpatient Order

- **YES**: Write an order for Inpatient Status: Document that the patient meets the two midnight benchmark, the expected length of stay and the medical necessity for inpatient care.

* If the physician writes an inpatient order and then after one day of treatment the patient can receive care at a lower level, change the status to observation with a condition code (44) through case management.

* If a patient discharges early because of death, leaving AMA, transferring to another facility or an unforeseen recovery, then the patient should remain in patient with supportive documentation.
Admission to Hospital - Two-Midnight Rule

Exceptions to the Rule

• Inpatient only procedures
• Newly initiated acute mechanical ventilation
• Not occurring, as would be anticipated, with a procedure
• Unforeseen Circumstances such circumstances must be documented:
  – Death
  – Transfer to another hospital
  – AMA
  – Unexpected clinical improvement
  – Election of hospice care
Two-Midnight Rule vs Observation Care

An observation status patient may be admitted to an inpatient status at any time for medically necessary continued care, but the patient can never be retroactively changed from observation to inpatient (replacing the observation as if it never occurred).

Physician orders to "admit to inpatient" or "place patient in outpatient observation" should be clearly written. Be aware that an order for "admit to observation" can be confused with an inpatient admit. Likewise, an order for "admit to short stay" may be interpreted as admit to observation by some individuals and admit to inpatient by others.
Observation Care Services

Billing Guidelines

• **Procedure Codes**: 99218, 99219, 99220, 99224-99226 and 99234-99236

• Outpatient observation services require monitoring by a physician and other ancillary staff, which are reasonable and necessary to evaluate the patient’s condition. These services are only considered medically necessary when performed under a specific order of a physician.

• Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patients, patients’ families, or while waiting placement to another facility.

• Outpatient observation services, generally, do not exceed 24 hours. Some patients may require a second day of observation up to a maximum of 48 hours.

• At 24 hours, the physician should evaluate patient’s condition to decide if the patient needs to remain in observation for an additional 24 hours.
**OBSERVATION CARE SERVICES**

- Hospital observation services should be coded and billed according to the time spent in observation status as follows:

<table>
<thead>
<tr>
<th>Time Spent</th>
<th>8 Hours or Less</th>
<th>&gt; 8 Hours &lt; 24 Hours</th>
<th>24 Hours or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code(s)</td>
<td>99218-99220 (Initial Observation Care)</td>
<td>99234-99236 (Observation or Inpatient Care)</td>
<td>99218-99220 (Initial Observation Care)</td>
</tr>
</tbody>
</table>

- **Same Calendar Date**
  - Admission paid
  - Discharge **not** paid separately

- **Different Calendar Date**
  - Admission and Discharge (99217) paid separately

- **Same Calendar Date**
  - Admission and Discharge Included

- **Different Calendar Date**
  - Use codes 99218-99220
  - Discharge (99217) paid separately

- **Same Calendar Date**
  - Admission paid
  - Discharge **not** paid separately

- **Different Calendar Date**
  - Admission and Discharge paid separately
Observation Care Services

• Subsequent Observation Care Codes are **TIME-BASED CODES** and time spent at bedside and on Hospital floor unit must be documented by the physician.

• At 48 hours, the physician should re-evaluate patient’s condition and decide if patient needs to be admitted to the hospital or discharged home.

• Outpatient observation time begins **when the patient is physically placed in the observation bed.** Outpatient observation time ends at the time it’s documented in the physician’s discharge orders.
Non-Physician Practitioners (NPP’s) or Physician Extenders

Who is a NPP?

Physician Assistant (PA)
Nurse Practitioner (NP)
Shared Visits

• The shared/split service is usually reported using the physician's NPI.

• When an E/M service is a shared encounter between a physician and a NPP, the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient and can be billed under the physician.

• If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the non-physician's NPI.

• Procedures **CANNOT** be billed shared
Shared Visits Between NPP and Physician

Shared visits may be billed under the physician's name if and only if:

1. The physician provides a medically necessary face-to-face portion of the E/M encounter (even if it is later in the same day as the PA/ARNP's portion); and

2. The physician personally documents in the patient's record the details of their face-to-face portion of the E/M encounter with the patient.

- If the physician does not personally perform and personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter cannot be billed under the physician's name and must be billed under the NPP.

- The NPP MUST be an employee (or leased) to bill shared. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician.
Bill Independently and Not Shared

Billing Under The NPP NPI

• Does not require physician presence.

• Can evaluate and treat new conditions and new patients.

• Can perform all services under the state scope-of-practice.

• Can perform services within the approved collaborative agreement.

  • Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.
“Incident to” Provision

• Incident-to services are those services commonly furnished in a physician’s office (POS 11) that are “incident to” the professional services of a physician.
• Physician must personally perform an initial service for each new patient or new condition, make an initial diagnosis, and establish a treatment plan.
• Physician must personally perform subsequent services at a frequency that reflects his/her active participation in and management of the course of the treatment for each medical condition.
• Services must be performed under a physician’s direct supervision: (Present in the office suite and immediately available to provide assistance and direction throughout the time the ancillary staff, ARNP, PA is performing the “incident to” services.)
• Incident-to provision does not apply in the hospital settings, Inpatient (POS 21), Outpatient (POS 22) or ER (POS 23).
• If all “incident to” requirements are met, the services provided by the ancillary staff, NPPs (ARNP, PA, etc.), are billable under the supervising Physician’s NPI number.
• If “incident to” requirements are not met, then the services provided by the NPPs are to be billed under the NPP’s NPI number.
ICD-10
Looks like a go!
Diagnosis Coding
International Classification of Disease (ICD-10)

- ICD-10 is scheduled to replace ICD-9 coding system on October 1, 2015.
- ICD-10 was developed because ICD-9, first published in 1977, was outdated and did not allow for additional specificity required for enhanced documentation, reimbursement and quality reporting.
- ICD-10 CM will have 68,000 diagnosis codes and ICD-10 PCS will contain 76,000 procedure codes.
- This significant expansion in the number of diagnosis and procedure codes will result in major improvements including but not limited to:
  - Greater specificity including *laterality, severity of illness*
  - Significant improvement in coding for primary care encounters, external causes of injury, mental disorders, neoplasms, diabetes, injuries and preventative medicine.
  - Allow better capture of socio-economic conditions, family relationships, and lifestyle
  - Will better reflect current medical terminology and devices
  - Provide detailed descriptions of body parts
  - Provide detailed descriptions of methodology and approaches for procedures
UHealth/UMMG
2015 PQRS

Patient Safety and Quality Office
CMS Quality Improvement Programs

- Meaningful Use (MU)
- Physician Quality Reporting System (PQRS)
- Value Based Payment Modifier (VBPM)
# CMS Quality Programs

## Medicare Part B Payment Reductions

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>POTENTIAL MEDICARE PAYMENT REDUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
</tr>
<tr>
<td>PQRS</td>
<td>1.5%</td>
</tr>
<tr>
<td>VBPM</td>
<td>4%</td>
</tr>
<tr>
<td>TOTAL PENALTIES</td>
<td>2.5%</td>
</tr>
</tbody>
</table>
# 2015 PQRS Eligible Providers

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Practitioners</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>Physician Assistant</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>DO</td>
<td>Nurse Practitioner</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Doctor of Podiatric</td>
<td>Clinical Nurse Specialist*</td>
<td>Qualified Speech-Language Therapist</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>CRNA</td>
<td></td>
</tr>
<tr>
<td>DDS</td>
<td>Certified Nurse Midwife</td>
<td></td>
</tr>
<tr>
<td>DMD</td>
<td>Clinical Social Worker</td>
<td></td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>Clinical Psychologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Registered Dietician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nutrition Professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audiologists</td>
<td></td>
</tr>
</tbody>
</table>
PQRS

Reporting Requirements:
- Reporting Period= Full CY
- Report 9 Measures from 3 National Quality Strategy Domains

Reporting Options:
- Claims, EHR, Registry
- Individual or GPRO

<table>
<thead>
<tr>
<th>NATIONAL STRATEGY DOMAINS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication &amp; Care Coordination</td>
</tr>
</tbody>
</table>

UJ Health
UNIVERSITY OF MIAMI MILLER SCHOOL of MEDICINE
Physician Impact

*Workflow and documentation changes*

**TO DO:**
- ✓ Study Measure Specifications
- ✓ Ensure documentation meets measure requirements
- ✓ Bill PQRS quality code when required in MCSL/UChart
- ✓ Document chronic conditions/secondary diagnoses
- ✓ Use UChart Smart Phrases
- ✓ Ensure medical support staff completes required documentation
Clinical Trials
Effective for claims with dates of service on or after January 1, 2014 it is mandatory to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED.

**Professional**

- For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) (do not use CT on the electronic claim, e.g., 12345678) when a clinical trial claim includes:
  - ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  - **Modifier Q0** (investigational clinical service provided in a clinical research study that is in an approved clinical research study) and/or
  - **Modifier Q1** (routine clinical service performed in a clinical research study that is in an approved clinical research study), as appropriate (outpatient claims only).

**Hospital**

- For hospital claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:
  - Condition code 30;
  - ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  - Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

*Items or services covered and paid by the sponsor may not be billed to the patient or patient’s insurance, this is double billing.*
WHO IS RESPONSIBLE FOR OBTAINING APPROVAL FROM THE MAC(S) FOR AN INVESTIGATIONAL DEVICE EXEMPTION (IDE) CLINICAL TRIAL?

The principal investigator (PI) is responsible for assuring that all required approvals are obtained prior to the initiation of the clinical trial. For any clinical study involving an IDE, the PI must obtain approval for the IDE clinical trial from the Medicare Administrative Contractor (MAC) for Part A / Hospital.

Additionally, for clinical studies involving an IDE, the PI is responsible for communicating about the trial and the IDE to the Medicare Part B (physician) MAC.

Once approval has been received by the MAC, the following needs to take place:

• The Study must be entered in the Velos System within 48 hours.
• The PI is responsible for ensuring that the IDE or the no charge device is properly set up in the facility charge master to allow accurate and compliant charging for that device before any billing will occur.
Investigational Device Exemption (IDE)

Hospital Inpatient Billing for Items and Services in Category B IDE Studies

• Payment for the device may not exceed the Medicare-approved amount for a comparable device that has been already FDA-approved.

Routine Care Items and Services

• Hospital providers shall submit claims for the routine care items and services in Category B IDE studies approved by CMS (or its designated entity) and listed on the CMS Coverage Website, by billing according to the clinical trial billing instructions found in §69.6 of this chapter [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuels/downloads/clm104c32.pdf], and as described under subsection D (“General Billing Requirements”).
Investigational Device Exemption (IDE)

Category B Device. On a 0624 revenue code line, institutional providers must bill the following for Category B IDE devices for which they incur a cost:

• Category B IDE device HCPCS code, if applicable
• Appropriate HCPCS modifier
• Category B IDE number

• Charges for the device billed as covered charges

• If the Category B IDE device is provided at no cost, outpatient prospective payment system (OPPS) providers must report a token charge in the covered charge field along with the applicable HCPCS modifier (i.e., modifier – FB) appended to the procedure code that reports the service to furnish the device, in instances when claims processing edits require that certain devices be billed with their associated procedures. For more information on billing ‘no cost items’ under the OPPS, refer to chapter 4, §§20.6.9 and 61.3.1 of this manual.
WHEN THE TRIAL ENDS OR REACHES FULL ENROLLMENT?

When the trial ends, whether due to reaching full enrollment or for any other reason, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the item in the charge master so that it may no longer be used.

If the device is approved by the FDA and is no longer considered investigational or a Humanitarian Device Exemption (HDE) and will continue to be used at UHealth, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the investigational device in the charge master and to ensure that a new charge code is built for the approved device. At this point, ongoing maintenance responsibility would transfer to the relevant Revenue Integrity Office (s).
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!!

• Never share your password with anyone and no one use someone else’s password for any reason, ever – even if instructed to do so.

✓ If asked to share a password, report immediately.
✓ If you haven’t completed the HIPAA Privacy & Security Awareness on-line CBL module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development__training_office/learning/ulearn/
• HIPAA, HITECH, Privacy & Security
• Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

• What is Fair Warning?
• • Fair Warning is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
• • Fair Warning protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.
• • Fair Warning is an initiative intended to reduce the cost and complexity of HIPAA auditing.

• UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: http://www.med.miami.edu/hipaa
Available Resources at University of Miami, UHealth and the Miller School of Medicine

- If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  - Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; or
  - Iliana De La Cruz, RMC, Director Office of Billing Compliance
    - Phone: (305) 243-5842
    - Officeofbillingcompliance@med.miami.edu

- Also available is The University’s fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24 hours a day, seven days a week).

- Office of billing Compliance website: www.obc.med.miami.edu